NOTICE OF FUNDS AVAILABLE FOR COMMUNITY HEALTH CENTERS

DATE: March 18, 2003

TO: Community Health Centers, Maternal and Child Health Projects, Other Health Care Providers

FROM: Office of Primary Care
Community Health Development Services Commission
Indiana State Department of Health

SUBJECT: Notice of Funding Available - Includes Community Health Center Application

This announcement of availability of funding is sent to you due to your status as a current or recent provider for the Indiana State Department of Health (ISDH) or a known public health partner. This letter announces the availability of funding for primary care projects and provides the instructions to submit an Application to ISDH no later than close-of business April 30, 2003.

Fifteen million dollars ($15M) is available for Community Health Center (CHC) clinic operations and up to one million ($1M) additional dollars is available for CHC capital projects. (CHC capital funding is directed to currently identified state CHC projects. Due to the limited amount of capital dollars and the expected demand, preference will be granted to those CHC projects currently not receiving CHC capital funding and to those projects with a demonstrated immediate ability to increase primary care or dental capacity. Applicants are discouraged from spending significant money to develop new large capital applications. Applicants may contact Jonathan Mack at (317) 233-8651 with questions regarding capital funding.) CHC funding is for state fiscal year 2004, the period of July 1, 2003 through June 30, 2004. For entities already funded by the CHC program, budgets for clinic operation should not be higher than an additional ten- percent greater than the current ISDH CHC contract. New applicants should not request more than $150,000 for operational services. **NOTE: This announcement is based upon the most current information of the budget of the State of Indiana. Further action within the process of government regarding all three branches could result in changes to funding available. Grants will be funded for one year, with a one year renewal that can be invoked dependent upon a successful review by ISDH of the entity's performance, coupled with a viable fiscal plan.**

ISDH announces the opportunity for providers to propose projects that address the **objective** of increasing access to primary care and funding services that directly impact

identified local health needs as determined by public health data. The **Application is attached to this notification and includes all information required for an ISDH review committee to make funding decisions for state and federal fiscal years 2004.** Note that the Application must be fully completed by interested applicants in order to be eligible for review. ISDH continues to attempt to provide the best possible stewardship of funding provided by the Indiana State Legislature to better address the health care needs of uninsured, underinsured and working poor citizens of Indiana.

Resources will be focused on funding services that address the following ISDH priorities:

- Health Professional Shortage Areas (HPSA's), Medically Underserved Areas (MUA's), counties with inadequate child health providers as identified by the Office of Medicaid Policy and Planning (OMPP)
- Increase access to primary health care, including dental care, for the uninsured, underinsured, and working poor
- Decrease health disparities
- Address chronic disease morbidity and mortality through better management of chronic diseases such as **diabetes**, cardiovascular, asthma, and obesity
- Decrease infant mortality, low birth weight, and very low birth weight

HOW TO ACCESS ISDH DATA

Applications must indicate that the applicant will provide services addressing the **specific health needs of the community or service area based on public health data.** A copy of the Application and a link to the health data may be accessed at:

http://www.in.gov/isdh/programs/community/index.htm

then scroll down and click Funding Availability**.**

- Direct data sites for: MUA/HPSA data: http://www.bphc.hrsa.gov/bphc/database.htm
- Health data: http://www.in.gov/isdh
- Poverty data: http://www.stats.indiana.edu/welfare_topic_page.html
- "Best Practice" guidelines for pregnant women: http://www.indianaperinatal.org
- Infant Death & Low Birthweight review: http://www.indianaperinatal.org/Images/infantdeathlbw.pdf

THE PROCESS

- Complete the Application attached to this notice of funding availability.
- Number all pages sequentially.
- Submit an original and three copies and a disk of the Application no later than the close of business **April 30, 2003** to:

Indiana State Department of Health
Community Health Development Services Commission
ATTENTION: Patrick Durkin
2 North Meridian Street, 8th Floor
Indianapolis, IN 46204

Applications will be read by an ISDH Review Committee comprised of staff from the Community Health Development Services Commission (Office of Primary Care, Maternal and Child Health Services, Local Liaison Office) and others within ISDH.

Applications will be prioritized using the following factors:

Addresses specific local health priorities
Addresses a chronic disease health system delivery model
Demonstrates need based on local data
Demonstrates collaboration with other ISDH funded projects or organizations within the community or service area
Demonstrates measurable outcomes
Produces a best practice or replicable model
Addresses participation in the Shared Integrated Management Information System.

Please note that the ISDH Office of Primary Care is interested in these applications explaining how the individual centers plan on providing comprehensive primary care services to the uninsured, working poor, and underinsured residents of the cachement area. A detailed budget must be included. Also, new this year, are six performance measures, five of which are mandatory. These are included in the application and represent basic comprehensive primary care practice.

Final funding decisions will be made by the ISDH Review Committee.

The Application will be used to award funding. Considerable discussion with ISDH staff may be required to finalize the contract. Additional program and/or revised budget information will need to be submitted after funds are awarded, and prior to issuance of the contract, to insure that all ISDH requirements are met.

There will be a meeting on March 20, 2003, from 1:30 a.m. to 3:00 p.m. (Indianapolis time) in Rice Auditorium at ISDH, 2 North Meridian Street, Indianapolis, IN at which Dr. Gregory Wilson, State Health Commissioner will share his ideas regarding the efforts of Community Health Centers focusing on diabetes management in Indiana. The revised application process will be reviewed, there will be a demonstration of how to access data, and there will be breakout sessions after the meeting to discuss completion of the Application form. Individuals who wish to attend the March 20, 2003 meeting must R.S.V.P. Patrick Durkin by phone at (317) 233-9261, FAX (317) 233-7847, or e-mail: pdurkin@isdh.state.in.us. Space is limited, so please do not send more than two (2) persons from your organization to the meeting.

Questions regarding the application process may be directed to Jonathan Mack, Director of the Office of Primary Care, at (317) 233-8651.

Attachment: Application

Application

Applicant Information Page (Form A)

All applicants must complete all items on Form A. This is to be submitted as the first page of the Application**.** If the information is not applicable, indicate NA**.** Note that **all signatures must be obtained.**

Table of Contents

The table of contents must indicate the page where each section begins, including appendices.

Proposal Narrative

Begin this page with the legal name of the organization and the title of the project (if appropriate). The narrative will provide a succinct and clear overview of the organization, including:

Applicant Agency Description

- **What is the purpose of your organization?** What is your mission statement, your goals and objectives, future plans?
- **Describe your organization's operating structure** including how the project will function within the total organization - Attach an organizational chart. Submit a list of the Board of Directors including names, addresses, and positions and the percentage of the board that are clinic users. Maintain copies of current licenses and certifications for all professional staff in personnel files.
- **Describe your service area(s)** and site locations using streets, census tracts, and/or other detailed descriptions as appropriate - Attach detailed maps. Identify project locations/sites and discuss how they will be an asset to the target population and the project.
- **What components of comprehensive primary care does your center provide?** See the Check List in the application appendix. How do your patients access services that your center does not have.
- **How do you and local organizations and local healthcare providers collaborate on this project and on other health related issues. i**dentify the role of each organization/provider and specify how each collaborates with your organization. Attach MOU's/MOA's if not previously submitted to the Office of Primary Care.

Statement of Need

- **State why your Center is needed.** What services does the center provide that is not met by other health care providers in your area.

- **Underserved area.** Establish need as determined by the number of **uninsured/underinsured patients who require comprehensive, prevention-oriented primary health care at a health care home.** This should be supported by data (data available on ISDH website, add appropriate updated local data)- Evidence must indicate problem(s) or need(s) exist in the proposed service area. Include a description of the target population(s) including numbers to be served. Include information on health profession shortage areas (HPSA), health professional shortage area populations (HPSA_POPs) medically underserved areas (MUAs), medically underserved populations (MUPs) or other special populations.
- **List organization/program data** summarizing total encounters and total patients served by site (separately identified as Medicaid, Medicare, fee scale, other insured, etc.) during most recently completed Calendar year. Describe your sliding fee schedule, application process, and billing process. Please include an estimate of percentage of bad accounts.

Outcomes and Performance Measures

- **Provide a narrative** and statistics describing current status of objectives as listed in last year's CHC applications
- **Complete the Performance Measures tables in Form D.** Please note that performance measures 2-6 are mandatory. Performance measure one is only mandatory if your entity provides such services.
- **Address** efforts toward implementing ISDH Chronic Disease Clinic and case management model.

Quality Assurance.

- **Extension of Services.** How does the center extend services and promote appropriate utilization of prevention services? How do the underserved find out about services?
- **Quality of Service.** How and how often will the quality of services be evaluated? Which staff will be responsible? What data will be collected? How will the data be measured and analyzed what measures will be taken if improvement in needed?
- **Participation in the local health system.** How does the center participate in and make referrals to the local health care system, including specialists, mental health care, hospitals and public health programs such as WIC family planning, and HIV?
- **Staffing** Describe how the organization will meet minimum 24 hour professional coverage requirements. Describe staffing and hours available for physicians and nurse practitioners with prescriptive authority. How do patients obtain care when the center is closed. Submit job descriptions and curriculum vitae of key staff in an appendix. Copies of current professional licenses and certifications must be on file.

- **HIPPA** Compliance: How are you addressing the **Health Insurance Portability and Accountability Act of 1996?**
- **Description of facilities** address the adequacy and accessibility for individuals with disabilities in accordance with the Americans with Disabilities Act of 1990, give assurance that the facility will be smoke-free at all times, and that will meet OSHA requirements for biohazardous materials, and that hours of operation are posted and visible from outside the facility (Include evening and weekend hours to increase service accessibility and indicate hours of operation at each site on **Form B2**)

Fiscal Needs

- **What plans does your center have to increase its income?** Include what efforts have been made this past year to increase both number of patients and income. How can your center become financially self sufficient
- **Budget Form 2** projecting expenses, and **Budget Narrative** projecting expenses/costs of services to be provided – The budget narrative, in outline format, must include justification for each line item (including mileage at no more than state rate of $.28/mile).
- **Form C** identifying all ISDH funds currently received by applicant by source, time period, and amount
- **Current endorsements** from relevant community organizations must be submitted as appendices along with MOU's/MOA's not previously submitted - Local health officer in each county in which propose services must be notified that organization is proposing services (signature of health officer on Form A is sufficient; if signature cannot be obtained, include copy of organization's letter to health officer in each service county advising of proposal submission to ISDH)

Project Description Forms B1 and B2

All applicants must complete **Forms B1 and B2.** These summary forms will become part of the contract and will also be used as fact sheets for each organization/project. Instructions follow:

- **Project Description Form B1-**must include at a minimum history of the project, problems to be addressed, and a summary of the objectives and work plan. Any other information relevant to the project may also be included.
- **FY2003 form B2-**Target Population and Estimated Number To Be Served-is for the individual clinic site(s) and is the number to be served with CHC funds
- Clinic Schedule-include days and hours of operation for each site
- Budget for Site-is the estimated CHC funds budgeted for the individual clinic site
- Services Provided in Funded Site-include only those services provided with CHC funds.
- Other Services Provided at Site-include all services offered at clinic site other than CHC funded services

All applicants must complete and submit **Form A, Form B1, Form B2, Form C and Budget.**

FORM A

PRIMARY HEALTH CARE–COMMUNITY HEALTH CENTER
TOBBACCO SETTLEMENT
APPLICATION
STATE FISCAL YEAR 2004

Title of Project _____ Federal I.D. # _____

Medicaid provider Number: _____ Medicare Provider Number: _____

FY 2004 Amount Requested: $_____ FY 2004 Matching Funds Contributed $_____

Legal Agency /Organization Name: _____

_____

Street City Zip Code

_____ _____ _____

Phone FAX E-Mail Address

_____ _____

Project Director (type name) Phone

_____ _____

Board President/Chairperson (type name) Phone

_____ _____

Project Medical Director (type name) Phone

_____ _____ _____

Agency CEO or Official Custodian of Funds (type name) Title Phone

_____ _____

Signature of Project Director Date

_____ _____ _____

Signature of person authorized to make legal And contractual agreement for the applicant agency Title Date

_____ _____ _____

Signature of County Health Officer County Date

Are you registered with the Secretary of State? Yes ☐ No ☐

FY 2004 **FORM B-1**

Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:		
Type of Organization: State ☐	Local ☐	Private Non-Profit ☐
Requested Funds: $_____	Matching Funds: $_____	Non-matching Funds: $_____
Sponsoring Agency:		
Project Description (Services provided with funds requested and all matching funds):		

Project Name:	Project Number:	# Clinic Sites

Clinic Site Address:	Clinic Schedule: (days & times)	Budget for Site (include matching funds):
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:	Services Provided in Budget for site (include matching funds):	
Target Population and estimated number to be served with CHC funds:	Other services provided at site (non-CHC):	

Clinic Site Address:	Clinic Schedule: (days & times)	Budget for Site (include matching funds):
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:	Services Provided in Budget for site (include matching funds):	
Target Population and estimated number to be served with CHC funds:	Other services provided at site (non-CHC):	

Clinic Site Address:	Clinic Schedule: (days & times)	Budget for Site (include matching funds):
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:	Services Provided in Budget for site (include matching funds):	
Target Population and estimated number to be served with CHC funds:	Other services provided at site (non-CHC):	

Clinic Site Address:	Clinic Schedule: (days & times)	Budget for Site (include matching funds):
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:	Services Provided in Budget for site (include matching funds):	
Target Population and estimated number to be served with CHC funds:	Other services provided at site (non-CHC):	

Clinic Site Address:	Clinic Schedule: (days & times)	Budget for Site (include matching funds):
Address:	City, State, Zip	
Telephone Number:	Fax Number:	
Counties Served:	Services Provided in Budget for site (include matching funds):	
Target Population and estimated number to be served with CHC funds:	Other services provided at site (non-CHC):	

FORM C

FUNDING CURRENTLY RECEIVED BY YOUR AGENCY
FROM THE INDIANA STATE DEPARTMENT OF HEALTH

LIST ALL SOURCES OF ISDH FUNDING

SOURCE	FISCAL YEAR	AMOUNT

TOTAL $_____

COMMENTS:

BUDGET INSTRUCTIONS

Materials Provided: The following materials are included in this section:

Budget Form - Anticipated Expenditures
Definitions of Budget Line Items

In completing the section, remember that all amounts should be rounded to the nearest dollar.

Budget Form—Primary Health Care Community Health Center Tobacco Settlement Operating Fund Proposed Expenditures

Include all projected costs of the project assigning them to the appropriate line item and column.

PRIMARY HEALTH-CARE COMMUNITY HEALTH CENTER
TOBACCO SETTLEMENT OPERATING FUNDS
PROPOSED EXPENDITURES FOR STATE OR FEDERAL FISCAL YEAR -2004

Applicant Agency: _____ 12 Month Budget Period: From _____ to _____

Category		Total Project Costs	CHC Request	Matching Funds	Non-Matching Funds
A. TOTAL PERSONNEL	Salaries				
	Fringes				
B. OPERATING EXPENSES					
Contractual Services					
Equipment					
Consumable Supplies					
Travel					
Rent and Utilities					
Communications					
Other Expenditures					
SUBTOTAL A					
SUBTOTAL B					
TOTAL					

BUDGET FORM

DEFINITIONS OF BUDGET LINE ITEMS

SCHEDULE A—PERSONNEL AND FRINGE BENEFITS

SCHEDULE B—OPERATING EXPENSES

CONTRACTUAL SERVICES

Contractual or Consultant Services

EQUIPMENT

Purchase of equipment not allowable with MCH Funds

TRAVEL

Conference Registrations
In-State Staff Travel
Out-of-State Staff Travel

CONSUMABLE SUPPLIES

Laboratory supplies, office supplies, etc.

RENTAL AND UTILITIES

Janitorial Services
Other Rentals
Rental of Equipment and Furniture
Rental of Space
Utilities

COMMUNICATIONS

Postage (including UPS)
Printing Costs
Publications
Reports
Subscriptions
Telephone

OTHER EXPENDITURES

Insurance and Bonding	
Maintenance and Repair	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

CHC APPENDIX

Complete the following assessment and return with the CHC application

General Requirements

- ☐ Established need as determined by the number of uninsured/underinsured patients who require comprehensive, prevention-oriented primary health care at a health care home.
- ☐ Access to primary health care in health professional shortage areas (HPSAs), health professional shortage area populations (HPSA-POPs), medically underserved areas (MUAs), medically underserved populations (MUPs) or other special populations. Special populations may include migrant and seasonal farm workers, the homeless, HIV-AIDS patients, ethnic minorities, the elderly, pregnant women, and others with special health needs and/or geographic, cultural and economic barriers to care.
- ☐ Sites are expected to make an effort to extend services and promote appropriate utilization of prevention services regardless of patients' age, gender or ability to pay. ***No one should be refused services***.
- ☐ Sites shall have an adjusted fee schedule policy that is available, printed and posted so those who need to take advantage of it may do so.
- ☐ Chart and documentation of service delivery for each patient shall be maintained.
- ☐ OSHA basic requirements for a workplace will be met.
- ☐ Sites shall be willing to participate in health professional's training programs.
- ☐ Administrative documents to include mission statement, by-laws, affirmative action policy, list of contracts and leases, hours of operation, and proof of liability insurance will be on file.

Staffing Requirements

- ☐ While projects may utilize several part-time staff, there should be at least one full-time physician or nurse practitioner with prescriptive authority available on site at least 32 hours per week to provide consistency and care continuity.
- ☐ Sites must demonstrate that all providers are licensed to practice in Indiana. Board certification or eligibility is preferred for physicians. Nurse practitioners and physician assistants must be nationally certified. Credentials must be current and in the individuals' personnel files.
- ☐ Sites should have at a minimum, one physician on site at least 20 hours per week that has hospital admitting privileges to the nearest local hospital.
- ☐ All patients should have 24-hour access to providers affiliated with their health care home. Twenty-four hour coverage may be arranged through shared call among the health center's employed providers or through shared call among a broader group of providers through formal arrangement. Phone answering services that refer patients automatically to the nearest emergency room are not acceptable.
- ☐ To accommodate patients, who are unable to access a site's providers during regular business hours, sites should provide flexible hours to meet the need of the community without sacrificing popular weekday service hours.

- ☐ Efficiency standards shall be maintained for staff with direct patient involvement including: CPR certification based on current American Heart Association standards; demonstration of basic medical & nursing skills competency for licensure and certification; special certifications for ALS, EKG and lab skills; and, job descriptions for all staff.
- ☐ Sites shall maintain on file an organizational chart of health professional staff, administrative staff, subcontractors, volunteers, etc. who provide services and administer other aspects of the center's operations.
- ☐ Sites shall maintain on file a list of staff positions indicating full time equivalencies of those positions that provide and administer primary care services.
- ☐ Educational and retraining opportunities should be in place to promote continuous quality improvement.
- ☐ State criminal background checks as appropriate at time of hire, personnel policies and procedures, and liability policies shall be in place.

Practice Guidelines

- ☐ Sites shall make use of local best practices for protocol development
- ☐ Sites shall participate in the local health system including referral systems for local specialists, local primary care providers and hospitals; mental health providers; dental health providers; emergency services provisions; and coordination and referral with public health programs (e.g. WIC, EPSDT, family planning, HIV, immunization and communicable disease).
- ☐ Sites shall have in place written practice guidelines or a process in place for evaluation of service delivery and outsource service arrangements.
- ☐ Sites shall have in place written practice guidelines for mid-level practitioners.

Facility Requirements

- ☐ The facility and lay out shall accommodate projected patient volumes and facilitate efficient patient flow to the best of its ability.
- ☐ The entrance to the facility shall indicate it is smoke-free through use of the universal symbol for non-smoking, as well as posting signboards throughout the facility.
- ☐ The facility shall be handicap accessible, including parking spaces, entrances, restrooms, etc. that are marked appropriately.
- ☐ Adequate space will be met according to DHHS/BPHC for examination rooms, lab space, record retention, waiting area, etc. OSHA requirements will be met for biohazardous materials.
- ☐ Facility hours of operation will be posted so they are visible from outside the building, as well as the after hours phone number.

Equipment/Supplies

- ☐ Inventories, warranties, service and maintenance agreements shall be kept on file.
- ☐ Sites shall submit an annual inventory of equipment purchased with State CHC funds costing over $500.00, and shall maintain records of all prior written approvals obtained for such equipment.

☐ Title to all property acquired with State funds by the grantee under the contract remains with the ISDH. These records will be subject to audit and/or inspections, as provided by law.

Community Participation/Collaboration

☐ All sites should participate in collaborative efforts with residents, other public and private health care services, community groups, and agencies in their delivery of primary health care services. Collaborative efforts should be designed to avoid duplication and improve integration of local health services.
☐ All sites should actively solicit financial assistance from the communities that the CHC operates within.
☐ MOAs/MOUs of collaboration with other health care providers, health and human service agencies, government agencies should be on file.

Components of Comprehensive Primary Care

☐ A list of services provided on site and through arrangement shall be on file at the site.
☐ Sites are not expected to be able to provide the full range of primary health care services. However, all services with an asterisk (*) must be provided at some level, either directly or through arrangement.
☐ Primary health care services by physicians and/or mid-level practitioners including treatment for acute disease and management of chronic disease
☐ *Preventive health services
☐ *Case management and outreach
☐ *Basic diagnostic laboratory services
☐ *Pharmacy services needed to complete treatment
☐ *Referrals to supplemental service providers
☐ *Health education and counseling
☐ *Diagnostic x-ray services
☐ *Cultural competence employing an understanding of emotional and social factors in assessment and
☐ *intervention for each individual client
☐ *Preventive dental
☐ *Optometric/eye care
☐ *Emergency services
☐ *Services often essential to maintain or regain health*
☐ Restorative dental services
☐ *Services often required to assure access*
☐ Transportation for patients who would otherwise lack access to care
☐ Translation services or bilingual staff

Governance
☐ There will be a local governing board of 9-25 members which are representative of the community and which will include at a minimum one-third consumers of the health care site (51% if the site is a FQHC). A governing board has responsibility for

reviewing and approving decisions regarding budgets, scope of services, hours of operation, payment policies and procedures, and staffing. A list of current board members and user status shall be on file.

- ☐ The local governing board will meet at a minimum 6 times per year. This will be documented and kept on file for review.
- ☐ The highest ranking paid employee of the organization will be responsible for supplying the governing board with current financials on each CHCs operating budgets at each board meeting. This will be documented and kept on file for review.

Quality Improvement Systems/Evaluation

- ☐ Sites shall maintain on file the site's ongoing quality improvement program, including provider performance, protocols and chart audits. As appropriate, it should describe how the quality improvement program relates to HEDIS or other managed care quality improvement programs.
- ☐ Sites shall maintain on file a complete set of administrative and clinical policies and procedures. A review process for policies and procedures shall be kept on file.
- ☐ Sites shall conduct chart audits on a regular basis as part of their quality improvement plan. The procedure for data collection and the results of chart audits shall be kept on file.
- ☐ Each facility shall have a written quality improvement process. The quality improvement process needs to make a critical examination of the clinical practice habits of the physician/mid-level practitioner staff. The review needs to consider professional knowledge, accuracy of diagnostic skills, appropriate therapies, appropriate consultations, competent decision making and malpractice judgements – settled or pending.
- ☐ Sites shall maintain on file copies of patient satisfaction surveys, as well as documentation of how often these surveys are conducted and how the information is utilized.
- ☐ Sites shall have a written disaster preparedness plan.
- ☐ Sites shall have a written plan for coordination, referral and appropriate utilization of local hospital emergency room services.

Ancillary Arrangement

- ☐ For those primary health care services not provided on site, MOAs/MOUs or contracts shall be on file documenting that referral arrangements are in place which ensure continuity of care.

Financial Management

- ☐ Sites shall have billing and collection procedures in place to maximize revenues as appropriate through patient fees on an adjusted fee schedule, through billing to third party insurers such as Medicaid, Medicare and private insurance. Sites shall be Medicaid and Medicare providers, or at a minimum have filed their application to be a Medicaid/Medicare provider.
- ☐ Sites will bill Medicaid and Medicare.
- ☐ Sites shall be willing to participate in Medicaid Managed Care as primary medical providers.

- ☐ Sites are required to have an adjusted fee schedule for patients.
- ☐ Sites shall have a business plan in place for maximizing self-sufficiency. The business plan shall demonstrate community support, including direct financial support and in-kind materials and services from other sources such as the local hospital, the City or Township and other local and public sources.

MIS System

- ☐ Sites shall have a financial management system in place for billing, accounting, budget, management, and other systems to maximize patient generated revenues. Sites shall demonstrate fiscal integrity by having accounting and internal control systems appropriate to the size and complexity of the organization.
- ☐ Sites shall have a system which accurately collects and organizes data for reporting and which supports management decision making, ideally integrating demographic, clinical, utilization and financial information to reflect the operations and status of the organization as a whole.

Provider Name:

CHC Performance Measure 1: Proportion of low birth weight births.

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP 2010
Annual Performance Objective: Reduce the percent of low birth weight infants among all live births to:	%	%	%	%	%	**5** %
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	%	
Numerator (N): # of live births in Project with birth weight < 2500 grams						
Denominator (D): # of live births in Project to women seen through 32 weeks who had at least 3 visits						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ YES ☐ NO DATA SOURCE: _____

Work Plan Measurable Activities	How will activities be Measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
1. 100% of all prenatal clients will receive preterm labor education at 20-24 weeks.	Min. chart audit (10 charts)	1. Chart audit	1st _____ 2nd _____ 3rd _____ 4th _____			
2. 100% of clients will be educated in appropriate weight gain at first visit.	Chart Audit for documented weight gain grid at first visit an each visit thereafter	Weight gain grid and chart documentation.	1st _____ 2nd _____ 3rd _____ 4th _____			
3. Semi annual review of all LBW births and neonatal deaths	LBW and Infant Death Screening tool will be used for review with summary of improvements to be made.	Documentation of LBW and neonatals Deaths reviewed twice a year.	1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			

Provider Name:

CHC Performance Measure 2: Proportion of children who have completed age appropriate immunizations by age 3.

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP 2010
Annual Performance Objective: Increase the percent of two-year-olds who have received the full schedule o age appropriate immunizations to:	%	%	%	%	%	**80** %
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	%	
Numerator (N): # of two-year-olds in Project who received full schedule of immunizations their 3rd birthday						
Denominator (D): # of children in Project who were seen more than 1 time during the fiscal year, were enrolled before 18 months of age, and were 24-35 months of ag on last day of fiscal year						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ YES ☐ NO DATA SOURCE: _____

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
1. ≥ 90% of children who are on a delayed immunization schedule will be identified ,provided with an immunization, or referred to provider for immunization.	1. Documentation of clinic procedure for identifying, and providing services. 2.Chart documentation.	1.Written clinic procedure. 2.Chart audit	1st _____ 2nd _____ 3rd _____ 4th _____			
Can system on 6th floor help			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			

Provider Name:

CHC Performance Measure 3: Proportion of clients who reduced or stopped smoking.

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP 2010
Annual Performance Objective: Increase the percent of clients served by CHC who reduce or stop smoking to:	%	%	%	%	%	**NA**
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve or baseline.)	%	%	%	%	%	
Numerator (N): # of clients served by Project who smoked at the initial visit who reduced or stopped smoking by last trimester or last visit.						
Denominator (D): # of clients served by Project who smoked at the initial visit for **1. Prenatal Care-** and were seen through 32 weeks of pregnancy, received at least 3 visits and delivered; or **2. Primary Care-** for at least two visits during the year.						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:** _____

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
1. 100% of clients will be asked if they smoke at the initial visit. (Charts should be flagged if clients are identifi as smokers.)	1.Chart documentation	1.Chart audit	1st _____ 2nd _____ 3rd _____ 4th _____			
2. ____% identified as smokers will have smoking status documented at every visit.	1.Chart documentation	1.Chart audit	1st _____ 2nd _____ 3rd _____ 4th _____			
3. 100% clients who want to stop smoking will be provided with resourc or referrals.	1.Chart documentation	1.Chart Audit	1st _____ 2nd _____ 3rd _____ 4th _____			

Provider Name:

CHC Performance Measure 4: Proportion of Adults receiving Hemoglobin A1c Measurement

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP2010
Annual Performance Objective: Determine the baseline and increase percentage of adults with Diabetes who had a Hemoglobin A1c measurement least once in the past calendar year.	%	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	%	
Numerator (N): # of diabetic patients with at least one visit to project who had at least one hemoglobin A1c measurement taken during the past calendar year.						
Denominator (D): # of unduplicated diabetics seen by the project at least once this past calendar year.						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ YES ☐ NO DATA SOURCE: _____

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
Flag charts of all diabetic patients.	Chart Audit	Chart Audit	1st _____ 2nd _____ 3rd _____ 4th _____			
Develop a protocol for obtaining Hemoglobin A1c for each diabetic.			1st _____ 2nd _____ 3rd _____ 4th _____			
Implement protocol.			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			

Provider Name:

CHC Performance Measure 5: Percentage of adults with Diabetes who received influenza immunization.

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP2010
Annual Performance Objective: Increase the number of adult diabetic patie who received an influenza immunization during the past year.	%	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	%	
Numerator (N): # of adult diabetic patients with at least one visit during the calendar yea who received an influenza immunization.						
Denominator (D): # of adult patients with at least one visit during in the calendar year.						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ **YES** ☐ **NO** **DATA SOURCE:** _____

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
100% of adult diabetic patients with at least one visit during influenza immunization period will receive influenza immunization during the calendar year.	Chart Audit	Chart Audit	1st _____ 2nd _____ 3rd _____ 4th _____			
All diabetic patients will receive a reminder to come in for immunization before the influenza season.			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			

Provider Name:

CHC Performance Measure 6: Adults with High Blood Pressure who have a blood pressure check.

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	HP2010
Annual Performance Objective : Determine baseline for the number of adults with high blood pressure who receive a blood pressure check.	%	%	%	%	%	%
Annual Performance Indicator [N/D x 100]: (Actual progress performance from which to improve.)	%	%	%	%	%	
Numerator (N): # of adult patients with diagnosed high blood pressure who visit the project at least once and who receive a blood pressure check.						
Denominator (D): # of adult patients with diagnosed high blood pressure who visit the project at least once.						

(For Annual Report use only)
PERFORMANCE OBJECTIVE MET: ☐ YES ☐ NO DATA SOURCE: _____

Work Plan Measurable Activities	How will activities be measured or demonstrated?	What documentation is used to measure?	Quarterly results	Adjustments in work plan	Problems	Staff Responsible
All adults will receive a blood pressure check every visit, unless reason for skipping procedure is noted in chart.	Chart Audit	Chart Audit	1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			
			1st _____ 2nd _____ 3rd _____ 4th _____			